PRISON HEALTH SERVICES
SEGREGATION LOG

6/25

Name: Reed, Ernest AIS 111914 DOB _____ UNIT _____ YEAR 2005

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																										NC	NC	NC	NC	NC	
JULY	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC																
AUGUST																															
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															

KEY: M – MEDICAL
D – DENTAL
P—PSYCHIATRIC
N/C-NO COMPLAINTS

NURSES SIGN AND INITIAL

PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, REED, Ernest (Print Name) 111914 (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
( ) Eyeglasses
( ) Dentures
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
( ) Crutches
(✓) Other describe A.B.D. Binder X 1

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Earnest Reed #111914 (Inmate) 7-7-05 (Date)

L. Ewing LPN (Witness) 7-7-05 (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
REED Ernest	111914	11-23-55	W/M	Easterling

PHS-MD-70005 (White – Medical File, Yellow – Security Property Officer)

 B 20

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7-7-05

To: Doc

From: HCU

Inmate Name: REED, Ernest **ID#:** ~~#1914~~ 111914

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

(1) Bottom Bunk profile, No prolong standing, No heavy lifting x 6mo. 7/7/05 – 1/7/06

(2) Abd Binder x 6mo. 7/7/05 – 1/7/06

Earnest Reed #111914

Date: 7/7/05 **MD Signature:** Dr. Narbonne/05 **Time:** 2:35 p.m.

60418

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 7/7/05 Time: 8am Facility: Easterling

Check all applicable CIC's being evaluated: __Card/HTN __DM__GI__ID__PUL__SZ__TB

SUBJECTIVE: n/p Hep C
no GI sx.

OBJECTIVE: BP 120/72 HR 68 RR 18 Temp 96.3 Wt 211 Peak Flow____

~~NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ~~ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities,; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

Head, [illegible] [illegible] [illegible], [illegible]
[illegible]: LTA [illegible] [illegible]
[illegible]: [illegible] [illegible] [illegible]
+ [illegible] Hernia
[illegible]: intact

SGOT: 22
SGPT: 22
GGT: 18
Bil: tot: 1.3
Prot: 6.9/4.1
Hgb: 15
14.1 / 3.6 | 21 / 0.9 | 143

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM			HTN/CARD			SZ			PUL			ID			GI (circled)			OTHER		
Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control		
G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F (circled)	P	G	F	P
Status			Status			Status			Status			Status			Status			Status		
I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S (circled)	W	I	S	W

PLAN: [illegible] [illegible] [illegible] of [illegible].
No [illegible] indicated.

F/U: Routine 90 days:_______Other 6 Months Problem List Updated: Yes (circled) No

[signature] MD.
Physician/NP/PA

Reed Earnest
NAME

111914
AIS#

M
GENDER

W
RACE

11/23/55
DOB

(Revised 2/28/05)

PHS
PRISON HEALTH SERVICES INCORPORATED

Attachment E, IMPP 10-127
Effective 3-22-91

DEPARTMENT OF CORRECTIONS

REFUSAL TO SUBMIT TO TREATMENT

Date: 2-24-05 Time: 10:30 (A.M.) P.M.

I have been advised by Medical Staff PHS

that it is necessary for me to undergo the following treatment:

Influenza shot

(Describe Operation Or Treatment)

The effect and nature of this treatment have been explained to me.

Although my failure to follow the advice I have received may seriously imperil my life or health, I nevertheless refuse to submit to the recommended treatment. I assume the risks and consequences involved and release the above named Medical Personnel, the Easterling (Name of Facility), and its agents and employees from any liability.

Inmate: George Reed 123606 Date: 2-24-05

Witness: [signature] Date: 2-24-05

Witness: [signature] Date: 2/24/05

DOC # 010-127-004

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Reed, George	123606	7-15-[illegible]	B/M	ECI

PHS-MD-70032

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Earnest Reed

Date of Birth: 11-23-55 Social Security No.: 424-74-3880

Date: 5-1-04 Time: _____ A.M. P.M.

This is to certify that I, Earnest Reed (Print Inmate's Name), currently in custody at the ECF (Print Facility's Name), am refusing to accept the following treatment/recommendations: S/C (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Earnest Reed (Signature of Inmate)** J Scott Lyon (Signature of Medical Person)

_____ (Witness) _____ (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Earnest Reed

Date of Birth: 11-23-55 Social Security No.: _____

Date: 4-26-04 Time: 7:45 am (A.M.) P.M.

This is to certify that I, Earnest Reed w/m 11/23/55 (Print Inmate's Name), currently in custody at the ECF (Print Facility's Name), am refusing to accept the following treatment/recommendations: refuse dental screening (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Earnest Reed (Signature of Inmate)** _____ (Signature of Medical Person)

Elissa Andrews (Witness) _____ (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

 6-B-110

PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Reed Earnest

Date of Birth: 11/20/53 Social Security No.: 111914

Date: 4/23/05 Time: 10^05 A.M. ~~P.M.~~

This is to certify that I, Reed Earnest (Print Inmate's Name), currently in custody at the Elmore (Print Facility's Name), am refusing to accept the following treatment/recommendations: S/C - No show (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Refuse to sign (Signature of Inmate)**

(Signature of Medical Person)

(Witness)

R Hammer COI (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Earnest Reed

Date of Birth: 11-23-55 Social Security No.: 424-74-3880

Date: 4-12-04 Time: 10:00 p.m. A.M. P.M.

This is to certify that I, Earnest Reed (Print Inmate's Name), currently in custody at the _____ (Print Facility's Name), am refusing to accept the following treatment/recommendations: SF 4-12-2004 (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Earnest Reed
(Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Earnest Reed

Date of Birth: 11-23-55 Social Security No.: 424-74-3886

Date: 3-11-04 Time: 9:23 A.M. P.M.

This is to certify that I, Earnest Reed Earnest Reed (Print Inmate's Name), currently in custody at the _____ (Print Facility's Name), am refusing to accept the following treatment/recommendations: _____ (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Earnest Reed (Signature of Inmate)** _____ (Signature of Medical Person)

Daniel Rouse CO1 (Witness) _____ (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Reed Earnest

Date of Birth: 11/23/55 Social Security No.: 11914

Date: 2/4/04 Time: 900 A.M. P.M.

This is to certify that I, Reed Earnest (Print Inmate's Name), currently in custody at the Easterling (Print Facility's Name), am refusing to accept the following treatment/recommendations: SC (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Refused (Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Earnest Reed

Date of Birth: 11-23-55 Social Security No.: 424-74-3880

Date: 2-25-04 Time: 7:15 p.m. A.M. P.M.

This is to certify that I, Earnest Reed (Print Inmate's Name), currently in custody at the CHTC (Print Facility's Name), am refusing to accept the following treatment/recommendations: S/C 2-25-2004 (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Earnest Reed (Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: Reed, Earnest BCDC#: 111914

1. I agree to having dental X-Rays taken of my teeth and jaws in order to determine my dental problems.

2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.

3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.

4. I have had the opportunity to ask questions which have been answered to my satisfaction.

5. I understand there is no guarantee of success or permanence of the treatment.

Earnest Reed
Patient's Signature

5-19-04
Date

D.D.S.
Dentist's Signature

5-19-04
Date

PRISON HEALTH SERVICES INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: Reed Earnest BCDC#: 111914

1. I agree to having dental X-Rays taken of my teeth and jaws in order to determine my dental problems.

2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.

3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.

4. I have had the opportunity to ask questions which have been answered to my satisfaction.

5. I understand there is no guarantee of success or permanence of the treatment.

X Earnest Reed
Patient's Signature

3/10/04
Date

Dentist's Signature

3/10/04
Date

PHS MD-70090